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'Leading Better Care': An evaluation of an accelerated coaching intervention for clinical nursing leadership development

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‘Leading Better Care’: An evaluation of an accelerated coaching intervention for clinical nursing leadership development

Abstract

Aim

Outcomes of an accelerated co-active coaching intervention for senior clinical nursing leadership development.

Background

Co-active coaching is characterised by a whole person approach, commitment to deep learning and conscious action through supportive compassionate and courageous coach-coachee partnership. The national leadership capabilities framework, *Step into Leadership*, was used for development and evaluation.

Methods

116 senior clinical nurse leaders attended one face-to-face induction day and received a total of 3-hours of one-to-one telephone coaching and two virtual peer group facilitated sessions. Evaluation used primarily qualitative descriptive methods with iterative review of emerging themes.

Results

Capability mapping indicated self-leadership development as the most frequently cited need. Improvements in self-confidence, capacity for reflection and bringing whole self into the work were reported to deliver enhancement in team and service performance.

Conclusions

Co-active coaching supported deep analysis by individuals. Focus on self, rather than behaviours provoked reflection on perspectives, mindsets, beliefs and approaches which can lead to more sustainable behaviour and support service change.

Implications for nursing management

Investment in a co-active coaching approach offers bespoke support for clinical leaders to develop self-leadership capability, a precursor to delivering positive impacts on care.

Keywords

Co-active coaching, clinical nurse leadership development, leadership capabilities, self-leadership, clinical culture

Introduction

‘... demand has increased for clinical nurses to take the lead in ensuring quality patient care, patient safety, and healthy practice environments...To assume leadership roles at the point of

service, nurses must master the essential knowledge and skills of clinical leaders.’ (Grindel, 2016, p 9).

In a healthcare culture demanding safety, clinical effectiveness and person-centred care, clinical nurse leaders hold a pivotal role (Scottish Government, 2008). As Grindel (2016) asserts, ‘point of service’ requires development of leadership capacity and capability to support delivery of these aims. Clinical nurse leaders are ideally positioned to develop a pro-active workplace culture positioned at the interface between strategic management and direct care delivery.

Demands placed on clinical nurse leaders are diverse and the means for their development complex (Dierckx De Casterlé et al 2008). Educational and service leaders must evaluate how they can most effectively prepare and support those in pivotal and influential positions to assure leadership which promotes excellence in care provision and values the care providers. There are specific skills that clinical leaders require - objective setting, teambuilding, assuring staff satisfaction and retention, improving patient outcomes, enhancing organisational performance and establishing a healthy work environment (Sherman & Pross 2010). However, underpinning these are less tangible assets that need to be nurtured. McGuire (2003 p2) describes these as the ‘informal, human systems that are the ‘translators’, or ‘transfer systems’, that create the human force or cultural capability for an organization’.

Background

A Scottish Approach to Clinical Leadership Development

Review of the Senior Charge Nurse (SCN) role in Scotland identified the role as pivotal in assuring delivery of safe, effective, person-centred care within wards and community settings. Effective nursing requires clinical leaders enabled to fulfil their role consistently and effectively (Scottish Government, 2008). Governmental response to these findings was annual investment in role development including developing leadership capability (McGuire & Ray, 2014), securing supervisory status for clinical leaders (Russell & McGuire, 2014), improving staff selection (Cerinus & Shannon, 2014) and focusing on succession planning (Duffy & Carlin, 2014). A key development was agreement of a more consistent role definition for senior clinical nurse leaders. This informed and shaped an education framework with four outcome areas – enhancing patient experience, ensuring safe and effective clinical practice, developing team performance and delivering organisational objectives (Leading Better Care, 2011).

In 2014, National Health Service (NHS) Scotland’s national education and training body, NHS Education for Scotland (NES), assumed responsibility for Leading Better Care (LBC) support. Building on earlier activity NES developed an online resource infrastructure (leadingbettercare.scot.nhs.uk). built around the LBC Education Framework and Leadership Capabilities defined in the Scottish Social Services Leadership Strategy (Scottish Social Services Council (SSSC), 2014). Step into Leadership, the SSSC Leadership Capabilities framework mapped generic leadership information and associated actions. Whilst developed for the social care workforce the Leading Better Care Steering Group considered it appropriate to adopt this generic framework for clinical nursing leadership development to reflect the Scottish policy drive towards

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health and social care integration. Using a common leadership framework was considered a useful contributor to developing more common ways of working.

Integral to the investment programme for 2015-16 was a bespoke coaching intervention targeted at senior nurses responsible for leading clinical teams. The remainder of this paper evaluates this coaching intervention in facilitating skills development, personal/professional reflection and translating leadership learning into practice that equipped participants for development of self, teams and wider organisation/service.

Rationale and approach to coaching clinical leaders

Coaching has been widely cited in the published literature as a contributory intervention for leadership development. From a pedagogical perspective coaching draws on adult, learner-centred and experiential models of learning (O’Flahery & Everson, 2005). Cox (2015 p27) argues that adult learning has ‘reached it’s (sic) zenith with the advent of coaching as a learning approach’. The coachee retains ownership of content and responsibility for outcomes of the process whilst the coach aids in unpacking issues that may cause certain behaviours and stimulates ideas or insights for change or problem-solving. Use of experiential strategies is fundamental to a coaching repertoire drawing on concrete experiences, reflective observations, abstract conceptualisations and active experimentation (Turesky & Dennis 2011).

The coaching process for clinical practice development has been described in a number of ways. Byrne (2007 p1987) proposes a model focused on clinical problem solving, placing individuals in real situations in which they directly explore and address problems occurring in particular clinical settings focused on *‘individuals designing their future – and that of their organization – and achieving excellence through setting personally and professionally challenging goals and committing to taking the actions necessary to achieve them’*. McNamara et al (2013 p2539) describe a coaching focus beyond clinical problems, supported by a coaching practitioner who may have no clinical background but explores wider life skills and attributes, as *‘a way of developing the individual for the role that he/she performed’*.

The co-active coaching approach is underpinned by a relationship, the nature and quality of which is characterized by a whole person focus and commitment to deep learning and conscious action through compassionate and courageous partnership between coach and coachee (Kimsey-House et al, 2011, Kimsey-House and Kimsey-House, 2015). ‘Co-active’ refers to a relationship between equals with both coach and coachee as active collaborators in the process. Irwin and Morrow (2005 p30-33) suggest that the co-active model is ‘atheoretical...founded in practical application and not derived from a theoretical base’. The theoretical foundation has been built retrospectively based on practical outcomes and reported impacts. Irwin and Morrow situate the evidence base in health-behaviour change theory drawing on constructs from social cognitive theory. Key constructs in the co-active model offer a reflective and investigative foundation for the coaching intervention (Table 1):

Table 1: Constructs for Coaching Reflection and Investigation (Irwin and Morrow 2005)

Beyond overt synergies between programme goals and the co-active model, findings of another NES study, *Best Start Leadership*, (<http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/maternity-care/about-us/current-projects/best-start-leadership-programme.aspx>), which adopted a co-active coaching approach, had shown promising outcomes and was positively evaluated. Synergies between the practical coaching proposition and over-arching objectives of Leading Better Care, to develop and to empower clinical leaders to deliver service transformation, appeared powerful.

The Study

Aim

To evaluate an accelerated, co-active coaching intervention offered to a cohort of 116 senior clinical nurse leaders across Scotland in enhancing their leadership capabilities.

Evaluation question

What contribution does an accelerated Co-Active coaching intervention make to the leadership capabilities of senior clinical leaders?

Method

This evaluation study was designed to assess the impact of a 5-month coaching intervention with senior clinical nurse leaders. The coaching approach adopted and refined for this study was based on Co-active principles involving: taking control of one's own destiny by invigorating the desire to evoke changes achieved through: helping individuals; reflecting on context; doing something different; and, recognizing the need to empower teams i.e., acknowledging that change cannot be achieved alone.

The study used a primarily qualitative descriptive method with iterative review of key themes (Schreier 2012) supported by quantitative measures of perceived change by coachees.

Data collection methods

A number of approaches, developed for the evaluation, were adopted to gather data:

1. Pre-coaching questionnaire - including quantitative and qualitative self-evaluation statements to provide baseline and subsequent indicators of change. Post launch day evaluation – questionnaire to assess readiness for coaching
2. Mid-point outcome measures included coach reports that were negotiated with clients. This was focused on engagement and improvement issues and monitoring outcomes that were emerging.
3. End-point client evaluation – quantitative/qualitative data focused on impacts against Development and Capability Criteria (Tables 2 & 3), repeating baseline self-evaluation and critique of perceived helpful/unhelpful elements of intervention and engagement with coach.
4. Sample telephone in-depth interviews (n=11) to develop cases studies through exploration of emerging themes. Responses were recorded and transcribed. This provided a broader sense of context to data and allowed emerging themes from ongoing analysis to be tested.

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Sample/Participants

This study provided coaching to 116 senior clinical nursing leaders nominated by their line managers, recruited from health boards across Scotland. Coachees were introduced to the coaching process through 3 launch days commencing November 2015. Coaching was delivered by Co-active coaches (n=16) recruited from the UK and internationally. All coachees took part in the evaluation study and were invited to provide questionnaire data. In-depth telephone interviews were undertaken with 11 coachees selected randomly from each of 11 participating health boards.

Induction and interventions

Profiles were completed by each coachee in advance of the launch day to support initial understanding of development goals and expectations and to provide data to inform matching to an appropriate coach. Matching of coach and participant was based on identified needs, prior experience and learning style and taking account of coach profile and experience. This process sought to take the place of more traditional ‘chemistry’ sessions.

The launch day was designed to orientate participants to the programme and provided face-to-face contact with coaches, introduction to coaching peer-groups and exploration of leadership and change in the context of participant roles. The launch day importantly provided a forum for initial contracting with coaches to accelerate the building of relationships. Coachees were given the opportunity at this stage and subsequently to change their coach.

Coaches were prepared for this meeting through an introduction to the ‘components’ (Development/Impact Areas) of Leading Better Care (Table 2), and the *Step into Leadership* capability framework (Table 3) to provide structure and context for potential discussions and a template for outcome/impact review:

Table 2: LBC Education and Development Framework (Leading Better Care 2011)

LBC Outcomes	Development/Impact Areas
Ensuring safe and effective clinical practice	Clinical leadership and teamworking; evidence-based, clinically effective practice; continuous quality improvement, and; patient safety.
Enhancing patient’s experience	Coordination of patient’s journey, clinical expertise, and, promoting a culture of person-centred care.
Managing and developing performance of team	Role modelling, facilitating learning and development and managing the practice setting.
Contributing to delivery of organisation’s objectives	Networking, service development and identifying political and strategic drivers.

Table 3: Step into Leadership Capabilities (SSSC 2014)

Leadership capabilities	Action
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Vision	Taking forward organisation's vision; ensuring team share vision, and are committed to achieving it, encouraging performance improvement
Self-Leadership	Critically reflecting on own leadership, using feedback and evidence to continually enhance own leadership capability; being resilient and focusing on outcomes; challenging discrimination and oppression
Motivating and Inspiring	Recognising, valuing and utilising individual and collective skills and strengths; working collaboratively with leaders from other organisations to inspire change; creating a culture of learning and continuous improvement, where everyone's contributions are valued; encouraging others to contribute to organisation's vision
Creativity and Innovation	Developing organisational culture which values evidence, innovation, creativity and sharing of ideas; supporting leadership capacity, professional autonomy and appropriate risk taking at all levels in the workforce; constructively challenging barriers to creativity
Empowering	Supporting professional autonomy and leadership from staff and people using services; empowering people to be innovative, and to take appropriate risks; valuing contributions of service users, carers, staff and community
Collaborating and Influencing	Building relationships based on trust and respect; leading or contributing to partnerships; influencing people over whom you have no authority, who may also have leadership roles; supporting collaborative approaches with people who use service; with workers at all levels in the workforce, managing a range of conflicting views, and working together to reach shared solutions.

The *Best Start Leadership Programme* provided a tested design for the coaching intervention that had been refined iteratively on the basis of feedback from participants and coaches for both efficiency and effectiveness. Feedback from these evaluations indicated that in addition to the three elements of coaching for leadership development described by Kinsler (2014) - specialist knowledge, coaching experience and credentials - contextual understanding, (which is not the same as a clinical professional background), and coach-coachee matching were important ingredients of the process. Thorough preparation of the coaches and participant profiling was therefore considered essential.

The coaching intervention comprised a series of integrated elements designed to prepare, elucidate, complement and accelerate healthcare leadership development. These included:

- Development of coach's strategic contextual oversight
- In-person/face-to-face coach/coachee leadership launch day
- 'Leadership Launchpad Resource' – written guidance and reflective exercises
- One-to-one Leadership Coaching (3 hours telephone-based plus interim support)
- Peer-Group Leadership Learning (2 hours telephone-based plus interim support)

The coaching intervention was delivered over a 5-month period for practical reasons driven by funding availability.

Coach selection and preparation

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Coaches were selected based on experience, a desire to work with health care professionals, experience and credentials. This included International Coaching Federation accreditation, formal Co-active training and a commitment to values based on partnerships and a relational rather than transactional approach.

Coach induction involved exploring lessons from the Best Start Leadership - underpinning philosophy and programme - including design, methodology, client groups, individually allocated client profiles, tools and resources available. Coaches were clustered to offer mutual support and additional points of contact/support from coaching coordinators were available. Supervision sessions for coaches to discuss challenges, issues and share learning as the coaching progressed were provided.

Data analysis

The study adopted a qualitative content analysis approach (Schreier 2012). Inductive content analysis involving coding of data transcripts was undertaken to identify emergent themes. Data was synthesised from all qualitative data sets to elucidate statistical trends and to expose a number of insights from the coaches.

Ethics/conflict of interest

Funding for the study was provided by Scottish Government. Ethical approval was not required as the study was classified as a service improvement project rather than a formal research study. All coachees were informed by e-mail of the purpose of the study and that return of the questionnaire was voluntary. Written consent was secured from coachees taking part in telephone interviews. Recent guidance on ethics and quality improvement projects (Healthcare Quality Improvement Partnership 2017), suggest a future study of this nature should be subject to ethics committee review.

Firefly provided anonymised data from coaching interventions and participated in gathering data from participants.

Findings

Key findings from the coaching intervention were: process - satisfaction and support derived from the coaching relationship and approach; outcomes - development of self-leadership was a foundation for achievement in all other capability areas.

Satisfaction with coaching experience

Considerable investment went into creating a positive and developmental coaching experience for participants. This included: recruitment of coaches with a shared Co-Active philosophy and training, and a range of backgrounds and experience; matching coach to coachees, holding face-to-face induction days, and; offering the option for coach transfers should coachees feel they did not 'gel' with their matched coach. Only one person withdrew from the coaching and no coachees asked to transfer. Evaluation of satisfaction included questions on perceived positive impact, beneficial relationship, enjoyment, support, stretch, insight and usefulness (1-5 Likert scale from

‘none’ to ‘great’ satisfaction). In all criteria perceptions substantially reflected the positive pattern captured in the overall experience. Most strongly endorsed were supportive relationships (over 70% highest score), applications of insight and stretch questions (over 60% highest score). Lowest was group coaching (25% highest scores).

Comments to accompany satisfaction measures elucidated outcomes and including staff retention,

"Prior to engaging in this process I could not see the potential in myself anymore and felt at a loss as to what to do about this as no longer liked what I saw in me to the point I contemplated accepting that it was time for me to leave the NHS."

and feelings of positivity and resilience,

Being given the opportunity to have this protected time of 1:1 coaching has allowed me to take time out for myself to reflect on me to see what I could do to change myself and learn of the impact this has on others but also to learn what I can do to sustain this feeling. I not only feel back to my "usual self" I see my career not ending in a negative way and see myself as having options and choices that I can make should I want to."

A further indicator of satisfaction with process was gained in the final evaluation of the study on potential improvements. Almost half of all participants stated that there was nothing that they wanted to be different or that was least helpful. Suggestions related to process rather than outcome improvements and included increased number/duration of sessions, opportunities for face-to-face coaching, technology challenges of joining peer coaching calls and a desire for more formal closure of the coaching experience i.e. a final face-to-face event.

Coachee perception of change achieved through coaching

Perceived change used a 5-point Likert Scale to encourage reflection on issues of confidence in managing change, clarity of purpose, ability to influence, effectiveness in leading, ability to articulate their vision and confidence in themselves as leaders. Participants consistently reported an increase in their self-evaluation ratings, highest for increased confidence (Rating score pre 3.20-post 4.25), ability to articulate their vision (Rating score pre 3.22-post 4.23) and influence others (Rating score pre 3.30-post 4.20) and clarity of their leadership purpose (Rating score pre 3.31-post 4.23).

In addition to numerical data of growing confidence and greater role clarity qualitative data emphasised how this was translating into practice through positive relationships with teams and the wider service.

"I was able to recognise where I was blocking myself and the team from developing and I was able to change this."

“I understand my role and the important part I can play in promoting change and the nursing agenda.”

“I am now leading my team and encouraging them to build on their own decision-making skills and mostly to feel their voices are heard.”

Exploring desired outcomes from coaching

Leadership development needs were appraised and explored against *Step into Leadership* outcome areas. Coach-coachee preparatory interviews involved identification of between 1 and 3 coaching goals. Whilst the spread of these were across the Framework the notably predominant outcome area was against ‘self-leadership’ which constituted 44% of the overall outcomes identified. Other outcome capabilities were vision, 10%, motivating and inspiring 14%, creativity and innovation 6%, collaborating and influencing 13% and empowering 15%.

This reflected an intentional focus and starting point for the programme that sustainable change requires self-knowledge and insight gained through the coaching relationship, and that it is shifts in mindsets and beliefs which ultimately impact on behaviours and in turn ripple out to teams and the wider service.

Analysis of themes exposed a number of insights underpinning self-leadership. These not only revealed to the nurse leaders something of themselves but how these attributes influenced their leadership of others.

The nine insights of emerging self-leadership and leading others arising from the data were:

- I matter
- I have a deeper understanding of myself
- I am more aware of my leadership impact
- I am more confident in my leadership
- I need to reflect (step back to lead forward)
- I have choices/options available to me
- I can influence even when I can’t control
- I can include others in leadership
- I am not alone

This progressive focus from acknowledging self as a leader, built confidence to lead through establishing a vision, setting a direction and mobilizing others reflected in the ‘nine insights’. This journey was revealed in reported accounts of progress and a series of case studies.

Participant Case studies

To more fully understanding the impacts of the coaching intervention 11 in-depth qualitative interviews were undertaken. These snapshots provided an opportunity to explore coaching

journeys and examples of self and service development. Findings reflected how change in individuals resulted in significant developments in the climate within clinical teams (Case Study 1); and service improvement that coachees ascribed directly to confidence gained through coaching support (Case Study 2).

Case Study Snapshot 1: Clinical team climate

Case Study Snapshot 2: Service improvement through enhanced confidence

Discussion

The core programme was generally very well received offering bespoke and responsive leadership development experience focused on agreed outcomes. Duration was largely influenced by availability of funding and the original proposal of a 9-month intervention was accelerated to 5-months. Reports on process indicated that coachees would have valued a longer period of support however perceived outcomes derived from the experience remained highly positive. Over half the participants would have wished to continue with coaching if that option had been available to them. For many, this was reflective of the fact that, although they had learned and started to apply that learning, this was at an early stage and there was additional learning and application to be harnessed and they were aware of this.

The evaluation highlighted several factors that enabled learning and action in practice to be achieved through the coaching intervention. There was evident value placed on the opportunity to explore issues with the coach who could assist coachees in standing back from the clinical situation to review their own needs and capabilities, those of their team and those of the wider service. This was clearly aligned to the proposed supervisory role advocated through Leading Better Care interventions (Russell & McGuire, 2014). The vast majority of participants (83 out of 86 responding participants) indicated that they would recommend coaching to a colleague, and many of them described already having done so. There was a real sense of a broader need for this type of development offering across the senior clinical nurse community. Examples of how these supported wider developments included descriptions of how issues explored or outcomes achieved fed into both supervision and revalidation.

Participants recognised the value of deep work on self, supported changing mind-sets and beliefs which led to behaviour change, and a more sustainable outcome; rather than starting from a focus on behavioural change (Keddy & Johnson p51).

A limitation of the study was data capture only from coaches and coachees due to constraints of time. Action to mitigate this were illustrative case studies of change in practice. Deeper evaluation of the study would be to undertake direct team climate measures and 360-degree evaluation of participants.

The accelerated nature of the coaching intervention clearly delivered reported impacts for participants. However, this focus or time-constraint necessitates longer term support by organisations outside the coaching timeline. It is unclear to what extent this was understood or to be facilitated by senior managers.

Implications for nursing management

The use of leadership and service outcomes-oriented frameworks provided focus and structure for coach-coachee interaction and whole person focus of the co-active approach appeared to give freedom to explore wider issues ('whole person') which ultimately impacted on the quality of leadership.

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The study started to demonstrate a ripple effect from individual leader, to team, to service. As would be anticipated from a short intervention the ripple effect was only beginning, however the programme indicates advantage in an accelerated leadership development approach and preliminary reporting of wider systems impact.

Co-active coaching introduced a balance of stretch and support - coaches ensuring the application of learning in practice, along with holding coachees to account for actions taken, or not. The focus of the coaching was on the whole person including thoughts and feelings, starting with issues that were a priority for the coachee, personal or professional, at the outset of each meeting. Coaches all had backgrounds in leadership roles and were able to draw on wisdom and experience to support and challenge coachees even when they had no direct experience of specific clinical problems.

A balance of individual and group coaching appeared beneficial in building support structures across the system and sharing common issues and insights, although it is important to report that one-to-one coaching was preferred. Integration of face-to-face induction and relationship building preceding remote support increased accessibility of and engagement with coaches and the wider coaching family. The strengths-based approach inherent in the Co-active coaching alongside deeper work on values and beliefs delivered personal and wider team and service impacts.

Co-active coaching contains many ingredients – strengths-based, values-led, action-oriented – demanding nurse leaders are actively engaged in a self-directed, goal-oriented way in terms of their own and their team’s development. Consideration must be given to how conditions and capacity can be built in to organisations which ensure new found confidence and skills are nurtured and harnessed to maximum effect.

Experience of using this approach with midwives and other health care leaders indicated that it is vital to develop the approach through a focus on continuous improvement and small tests of change in the process. Introduction of a pre-coaching questionnaire and a coach matching process facilitated an effective outcome in terms of the coach-coachee relationship for the vast majority of participants. The creation of peer support communities acted as a catalyst for cross-health board learning and opportunity to further develop the peer learning dimensions to share ideas and remain connected.

Conclusion

The co-active coaching approach described in this study is an evolution of earlier interventions of the Best Start Leadership Programme. It highlights that the Co-Active model was well received by senior clinical nurses who reported its value in building confidence and insight (self-leadership) which in turn created a positive ripple effective moving through individual, team, organisational and service levels.

Detailed description of a coaching approach for leadership development provides a potential prototype to be tested more widely. Whilst integral to its impact is ongoing refinement to context it offers an opportunity for clinical leaders to step back from the clinical pressures, reflect in a supportive environment that in turn introduces stretch, challenge and accountability in taking action offering the potential for enhanced team performance and positive service change.

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Tables

Table 1: Constructs for Coaching Reflection and Investigation (Irwin and Morrow 2005)

Investigative constructs	Coaching Questions
Expectancies	Can nurse leaders elucidate or articulate outcomes they wish to achieve?
Expectations	What might nurse leaders anticipate to be probable or possible consequences of their behaviours/leadership?
Self-efficacy	How do nurse leaders perceive their capability in bringing about change?
Reinforcement	How can challenge, accountability, acknowledgement and support promote self-analysis and deliver behavior change?
Acknowledgement	How does having their whole selves acknowledged for who they are and what they have to offer support or promote action or behaviour change?

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Illustrations

Case Study Snapshot 1: Clinical team climate

Case Study 1: *“I think because I have got so much out of it, I feel that everyone deserves this, or at least a form of it”*

Context & Challenges:

Newly created Senior Charge Nurse post, 6 months into post prior to starting the programme. Issues in terms of staffing; previous leadership; inconsistencies in processes. Overall lack of trust between staff/management.

Learning & Impact

... on self “A recognition of who I am as a person and what makes me tick ... and how that has really started to come out and shape my leadership.

... on staff/service “It’s completely different...I’ve tried to develop a close working team ...it was all about giving staff the responsibility ...the recognition that my team are more than capable of doing it ... When management come in they comment on how much more relaxed the place feels and how much better the staff look and are happier working. My sickness rates dropped from when I took over, from 25% to 3.5% in February 2016”

What’s Next?

“Keeping going with the momentum that I started with and that enthusiasm and desire to do the best job I can. Being more reflective within my role and recognising my qualities and accepting praise and acknowledging that I’ve done really well in the last 12 months in this post and taking credit for it.’

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Illustrations 2

Case Study Snapshot 2: Service improvement through enhanced confidence

Case Study 2: “A much more confident person has emerged...”

Context & Challenges:

New into post as a Charge Nurse. Taking charge of a well established team; some staff were quite overpowering and set in their ways

Learning & Impact

... on **self** “That I am a good leader and I need to have more confidence in myself and that I can do it.”

... on **staff/service** Changes to nurse/patient allocation and reporting process “The Consultants have noticed a change in that their nurses have more knowledge on the patients when they are going round with them on their ward rounds... there is more detail in the reports...they are coming out with more relevant information. Staff are not staying over their allotted hours because the report is not taking longer than the 30 mins”.

Changes to off-duty “...off duty was done around what people wanted to work and there was no looking at skill mix, how many people had nights, weekends ... and it wasn’t working. The programme gave me the confidence to take it forward. I’ve had the Unions in ... and its all sorted now”.

What’s Next?

“My big focus is going to be on care planning...so its about staff education, getting staff on board and pointing out why we need to do it...it’s going to take time but its Ok because I can take that step back and look and see the bigger picture...”